# Maryland AIDs Drug Assistance Program

## *Oxandrolone (Oxandrin) Prior Authorization Fax Form*

**FAX Completed Form to First Health Services Corporation 1-800-932-3921**
Questions call First Health Services 1-800-932-3918

Client Name_____ MADAP ID | 9 | 4 | | | | | | | | | |

## Instructions

In order for a MADAP client to receive oxandrolone (Oxandrin), the client's MADAP certification must meet the medical criteria listed on this form. The authorized prescriber must complete and submit this form for authorization. Clients must be diagnosed with HIV-related wasting syndrome as evidenced by a 10% loss in total body weight in less than four months and a BMI < 18.5. Male clients must have failed a clinical trial with both testosterone and nandrolone for HIV-related wasting syndrome.

## Clinician Certified Medical History and Current Status

1. What is the patient's sex? ☐ Female ☐ Male
2. Is the patient a candidate for alternative treatment **with testosterone or nandrolone?** ☐ Yes ☐ No
   (A trial with each agent is required)

   a.) Dates of prior treatment with testosterone: Start date _____ End date _____
   Treatment (check one): ☐ Was Successful ☐ Failed
   Reason for failure _____

   b.) Dates of prior treatment with nandrolone: Start date _____ End date _____
   Treatment (check one): ☐ Was Successful ☐ Failed
   Reason for failure _____

3. Patient demonstrates the following clinical signs of wasting?

| | |
|---|---|
| a) Patient has involuntary weight loss of more than 10% of total body weight in less than four months;<br>☐ Yes ☐ No | Weight (report at least 2 months):<br>Weight 1 _____ Date _____<br>Weight 2 _____ Date _____<br>Weight 3 _____ Date _____<br>Weight 4 _____ Date _____ |
| b) **and**, BMI < 18.5 (Normal BMI = 18.5 to 24.9)<br>☐ Yes ☐ No | Patient Height = _____<br>Patient's BMI = _____<br>BMI = [wt (lbs.)/ht$^2$ (inches)] x 703 |

## Prescriber Information (please complete legibly)

**Name:** _____ **DEA #** | | | | | | | | | |

**Address:** _____

**Office Phone:** | | | | | | | | | | **Fax:** | | | | | | | | | |

**Signature:** _____ **Date:**_____

Revised 4/15/2005